

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-042457

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

STATE FILE NUMBER

317  
FILED NOV 7 1963

500

3198

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) <b>Koch</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b <b>7 days</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Robert Koch Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>3737 LaSalle</b>	
Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print) First <b>Julia</b> Middle <b>R.</b> Last <b>Varga</b>			4. DATE OF DEATH Month <b>October</b> Day <b>18</b> Year <b>1963</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>1-19-86</b>	9. AGE (last birthday) <b>77</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Grader</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Liggett-Meyer</b>		11. BIRTHPLACE (City and state or country) <b>Hungary</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>					

13a. FATHER'S NAME <b>unknown</b>		13b. MOTHER'S MAIDEN NAME <b>unknown</b>		14. NAME OF HUSBAND OR WIFE <b>unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>332X</b>		17. INFORMANT <b>Records of Koch Hosp. - Koch, Mo.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 mos.</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>Cerebral arteriosclerosis</b>		
DUE TO (c) <b>332X</b>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Diabetes mellitus and chronic pyelonephritis</b>		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <b>10</b> a.m. <b>11</b> p.m. Month, Day, Year <b>10-11-63</b>			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE

21. I attended the deceased from <b>10-11-63</b> to <b>10-18-63</b> and last saw her <b>10-17-63</b> Death occurred at <b>12:30 a.</b> m. on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <b>Ellis L. Lipsitz</b> (Degree or title) <b>M.D.</b>	22b. ADDRESS <b>Robt. Koch Hosp. - Koch, Mo.</b>	22c. DATE SIGNED <b>10-18-63</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>10/19/1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>S.S. Peter &amp; Paul Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis Mo.</b>
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24. FUNERAL DIRECTOR <b>Thomas Kuter 2906 Williams</b>	25. DATE RECD. BY LOCAL REG. <b>10-18-63</b>	26. REGISTRAR'S SIGNATURE <b>John B. Murphy M.D.</b>
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(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DATE AMENDED

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VS 300  
Rev. 4/59

1 4000

2 2189

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County Board of Health

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed E. Levan Province

Licensed Embalmer No. 3403

P. O. Address 2906 Gravois

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.